DoD
Drug Abuse
Control

COMMANDER'S DIGEST

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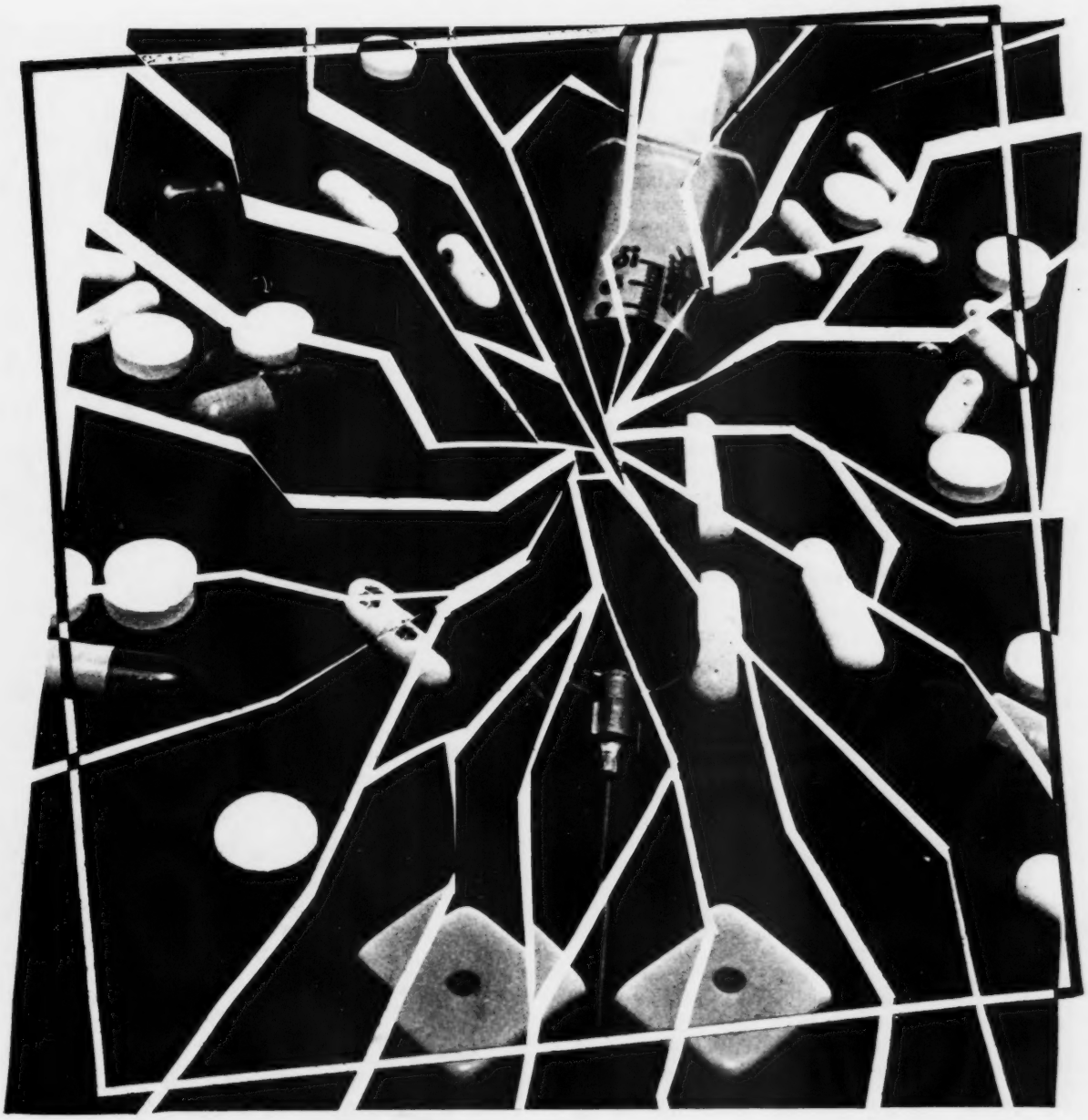

Drug Abuse Identification Program Objectives

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Improved Data and Deterrence

Objectives of Drug Abuse Identification Program

BY DR. RICHARD S. WILBUR
Assistant Secretary of Defense
(Health and Environment)

June 1973 marked the second anniversary of the counteroffensive against drug abuse in the Armed Services. When commanders recall the serious heroin epidemic U.S. forces encountered in Southeast Asia in the spring and summer of 1971, they may also recall the shift in policy and direction that we made from a strict law-enforcement, disciplinary approach to the new reliance on identification and treatment. I hasten to add that the law-enforcement, disciplinary aspects of drug abuse continue to be vigorously pursued in appropriate cases.

Our policy in the Department of Defense is to prevent drug and alcohol abuse within the Armed Forces and to attempt to restore members so involved to useful service. In this regard, the Department acknowledges a particular **responsibility for educating and protecting** members of the Armed Services against drug and alcohol abuse; **for identifying** members who use or promote the abuse of drugs and alcohol; and **for attempting to treat and rehabilitate** members who abuse drugs and alcohol, if they evidence a desire and willingness to undergo such restoration.

Identification Programs For Drug Abuse

We learned early in the summer of 1971 that the effectiveness of all our efforts to reduce and control drug abuse in the Services hinged upon successful efforts to identify the Service members involved.

The objectives of our identification program were threefold:

- To identify drug abusers at an early point, before serious physical or psychological harm had occurred, so treatment and restoration of health was relatively easy;
- To provide a degree of deterrence for some individuals who might otherwise be inclined to experiment with dangerous drugs; and
- To provide improved data on the prevalence of drug abuse by area in order that our programs may be better designed and directed.

The exemption policy, as it enables voluntary self-referral to treatment programs, is generally our most effective means of drug abuse identification. More than 69,000 Service members involved with drug abuse have volunteered to receive treatment and rehabilitation. [See top chart, page 6] This new approach is nonpunitive in that it exempts the Service member from any disciplinary proceedings for the personal use, or possession for personal use, of dangerous drugs.

Armed Services Did Not Invent Drug Abuse

I believe it important at this time to say that, contrary to some of the news reports one reads, the Armed Services did not invent drug and alcohol abuse. These problems arise within the same society from which our military manpower is drawn, so we are unable to separate the military drug and alcohol problem from that of our society at large. Because the health and vitality of the Armed Services are so important to our Nation's security, it has been natural for DoD and the Military Departments to lead the way in this crisis with vigorous, well conceived, innovative programs which are having a measurable impact on these serious problems.

The trends which are now evident in the military drug and alcohol programs lead us to an encouraging long-range view. Although the Armed Services may never be completely free of the abuse of dangerous drugs in the future, the incidence rate will continue to decline to a point farther below that of similar age groups in our society.

DR. RICHARD S. WILBUR
Assistant Secretary of Defense (H & E)

Additionally, if he is discharged from the Service as a result of his drug use, he will be discharged under honorable conditions. The Service member who requests assistance in recovering from his habit of drug abuse is carefully examined by a physician for physical or psychological results of his drug use and is enrolled in the appropriate course of treatment and rehabilitation. Some administrative actions, as opposed to disciplinary, may be required in certain instances. For example, security clearances may be suspended during the rehabilitation process and, in the case of aircrewmen, temporary or permanent grounding usually results.

The urinalysis screening program has also proven to be a most effective method of identifying drug abusers. Since this is an involuntary method of identification, we recognized that the confidentiality principles applied to other medical problems should have equal application here and that the same exceptions from punishment or discharge under other than honorable conditions must automatically be granted.

One of the most important lessons the Department of Defense has learned in the last two years is that drug abuse epidemics can be interrupted and reduced by a vigorous, properly administered urine drug testing program when directed at susceptible age groups in a random, unpredictable manner.

The Summer Of '71

Commanders remember, I am sure, the summer of 1971 when estimates of troop involvement with heroin in Vietnam were very high. The President announced the national counteroffensive against drug abuse. In response, the Secretary of Defense directed the commencement of drug testing for all Service members prior to their date of estimated return from overseas (DEROS).

Using new prototype equipment and the best Army technical personnel available, we started our program in June 1971 by commencing the DEROS test for all military personnel departing Vietnam. This program was expanded to include a random test for each Serviceman in-country as rapidly as test equipment and trained personnel became available to establish the requisite laboratories. The center chart on page 6 shows the results of those early efforts to reduce the drug epidemic by identifying the drug user before departure from Vietnam. When we expanded the testing program to include all U.S. forces on a random basis (see the bottom chart, page 6) we achieved a further rapid reduction in the incidence of drug abuse.

Our first testing efforts among Americans in Thailand were also centered around DEROS tests, but commander/physician-directed tests assumed a more important position as it was learned that symptoms of drug abuse in a unit or individual could be confirmed by urinalysis. The commanders and physicians were becoming quite skillful at directing the tests in the manner that would do the most good. The chart on page 7 shows the results of unannounced urinalysis screening for drug abuse in Thailand. The rapid rise between February and June 1972 demonstrates that our commanders knew which units had a drug problem. When we commenced random testing in Thailand in July 1972, the situation was nearly stable and remained so until December 1972 when a rapid rise in identifications was experienced simultaneously with a sudden increase in the availability of heroin. This trend toward an epidemic situation was disturbing, and we promptly commenced the necessary actions to increase the effectiveness of the random screening program and strengthen the overall drug prevention program.

In Europe, we experienced a similar situation when we began random testing in July 1972. We again experienced a rapid rise in the incidence of the abuse of dangerous drugs, coupled once again with a rapid increase in the availability of heroin. We instituted the necessary steps to control this outbreak by tightening the administration of the testing program, eliminating the serious problem of personnel not reporting for urine testing, increasing the frequency of the random testing, and emphasizing stronger leadership. The chart on page 8 shows the results of unannounced urinalysis screening in Europe. We now believe that a crisis had also been averted there.

The drug testing program is now enjoying increasing acceptance among commanders, physicians and even the troops as a logical means of protecting the health of Service members through identification and deterrence. We are also finding that a young Serviceman is much more likely to resist the pressure of his peers to join in illicit drug use, if he believes with some reliability that he might be tested tomorrow morning.

Education and Prevention

Services Conquered Early Program Difficulties

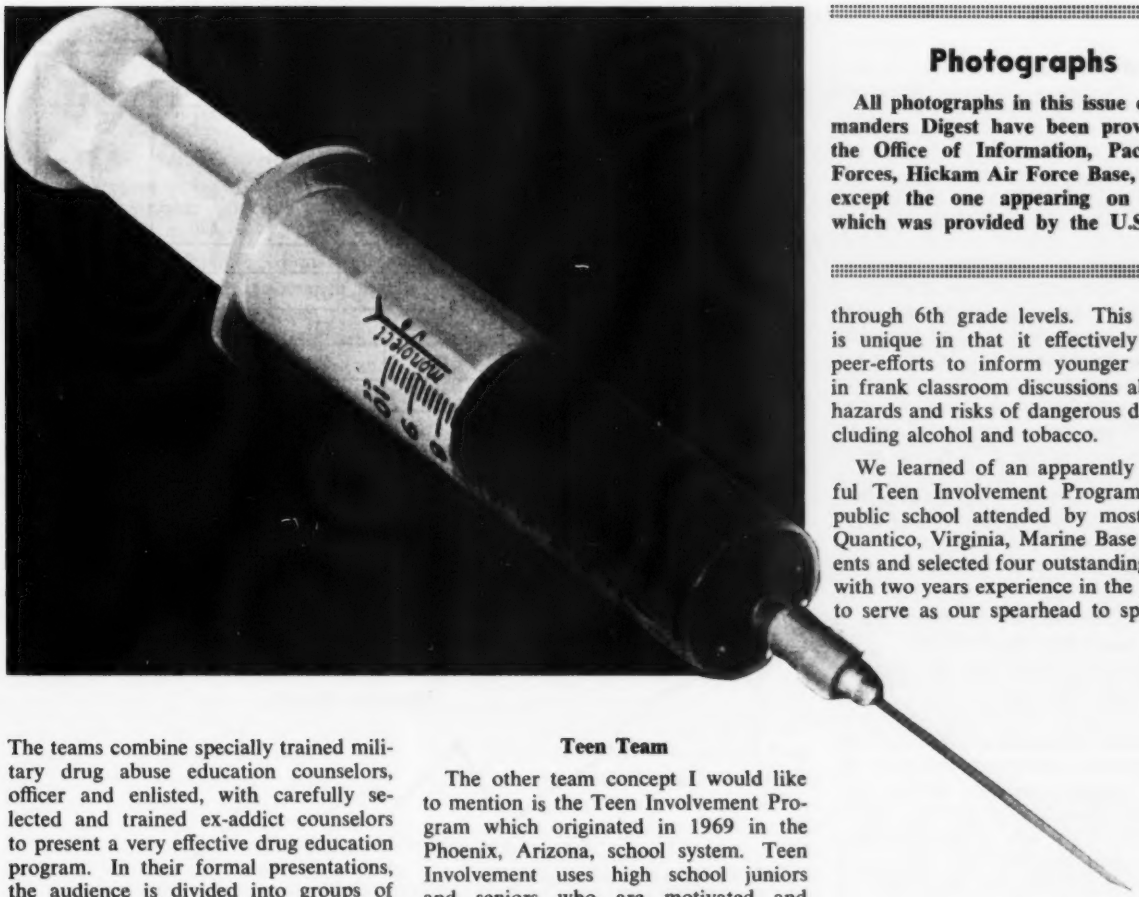
The Military Services encountered much the same difficulties in the beginning of our drug abuse education and prevention programs that had been experienced in the identification and treatment areas. We recognized that our level of knowledge and expertise related to drug abuse was very limited in the Services and that we would require expert technical guidance and know-how from the civilian side of the government and private agencies. With their help, we began training large numbers of enlisted drug education counselors to work at the unit level in assisting commanders in establishing effective prevention programs. Using many materials developed for civilian and commercial drug abuse education programs, we began a multimedia attack on the problem. American Forces Radio and Television Service, **Commanders Digest,** base newspapers, posters, rap sessions with concerned national personalities (such as Mr. Sammy Davis), Commanders Call, newsletters, and any other device available to the military audience was utilized to the maximum to get our message across to the troops, the leadership, the families, and nearby communities.

Many innovative ideas and techniques have proven successful. Among these are two types of drug education team programs, one for active duty personnel and one for dependent youth.

DEFT Touch

The Drug Education Field Teams (DEFTs) were first established in 1971.

USER REHABILITATION—Of the more than 83,000 military drug users treated in the Service drug programs between June 1971 and March 1973, 40,233 have been rehabilitated and returned to duty. As of March 31, 1973, 14,544 were still undergoing rehabilitation and 24,538 had been separated from the Service following completion of their rehabilitation.



Photographs

All photographs in this issue of Commanders Digest have been provided by the Office of Information, Pacific Air Forces, Hickam Air Force Base, Hawaii, except the one appearing on page 8 which was provided by the U.S. Navy.

The teams combine specially trained military drug abuse education counselors, officer and enlisted, with carefully selected and trained ex-addict counselors to present a very effective drug education program. In their formal presentations, the audience is divided into groups of young enlisted men, non-commissioned officers and officers. In this manner, peer groups are separated and communications flow more freely. The DEFT team is divided into two parts; one, composed of an enlisted man and one civilian ex-addict, gives a presentation to the group of enlisted men, while the other, consisting of the officer member and another civilian educator, addresses the officers and NCOs. In Asian areas, the team often includes a selected local national who explains the drug abuse prevention program to the native country nationals working on the military post. In addition to the formal presentations, the team members make themselves available to individuals and small groups with questions or problems. These informal contacts and communication at a peer level have provided some of our most effective informational exchanges.

Teen Team

The other team concept I would like to mention is the Teen Involvement Program which originated in 1969 in the Phoenix, Arizona, school system. Teen Involvement uses high school juniors and seniors who are motivated and trained for this type of work to serve as drug education specialists in the classrooms of elementary schools at the 4th through 6th grade levels. This concept is unique in that it effectively utilizes peer-efforts to inform younger students in frank classroom discussions about the hazards and risks of dangerous drugs, including alcohol and tobacco.

We learned of an apparently successful Teen Involvement Program in the public school attended by most of the Quantico, Virginia, Marine Base dependents and selected four outstanding seniors with two years experience in the program to serve as our spearhead to spread the program to other Defense-impacted schools. Their purpose during the past year was to inform educators, teachers, school boards, parents and community leaders of the opportunities of Teen Involvement and to train a cadre of high school students to conduct the program in school systems which invited our team. As a result of their efforts this past year, the Teen Involvement Program is now established in 14 school districts serving 100 elementary schools on or near military bases. We are expecting valuable benefits from this program and anticipate that we will soon be able to measure the attitude changes which will have occurred in the subjects as they arrive in high school.

The Military Services have constantly

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evaluated their older materials prior to replacing them with the new, gradually upgrading all their programs in this manner. We believe that our prevention programs, as presently devised are as up-to-date and effective as any in the Nation, but we keep an open mind on this score, and will continue to heed the best advice available in the educational field.

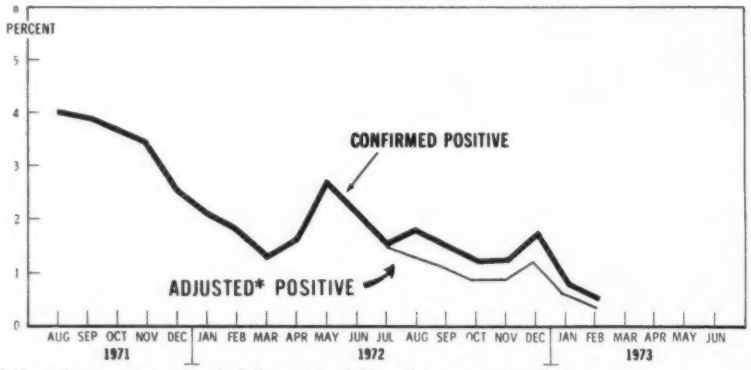
We are very certain of one thing in this vital area of drug abuse prevention: we know that every Service member is thoroughly exposed to the necessary information upon which to base an intelligent personal decision to use or not use dangerous substances. This process begins upon his first entry into the Service and continues periodically until his release. Of course, the difficulty in all of this is that he may have already made his decision, perhaps a negative one by default, during his earlier school days. The best we may be able to do is to provide a wholesome environment in the military where the peer and leadership pressures to abstain are so great that he will not again become involved.

We are also certain that the attitudes of the leadership corps of all the Armed Services are also rapidly changing as a result of the investment the Military Departments have made in appropriate officer and non-commissioned officer training. Drug education courses have been in operation at all officer candidate schools, non-commissioned academies, NROTC universities, Service academies, senior Service schools, and the war colleges. Even though attitudinal changes are difficult to measure, we believe that we are observing such an important change among troop leadership, including a new awareness of the drug and alcohol problem, that it will be significant in our future efforts to prevent abuse. You may not be aware of the fact that the abuse of hard drugs is practically nonexistent within the present commissioned and non-commissioned corps of officers. If these attitudes of non-use can be effectively translated into action in the same manner that most other personnel, health and morale problems are solved in the military, that is, through good, strong-line leadership, then we will be a long way down the road to total success in our prevention programs. We believe we have already seen this principle work in Vietnam and are continuing to see it work to a larger extent in other high risk areas.

Volunteers

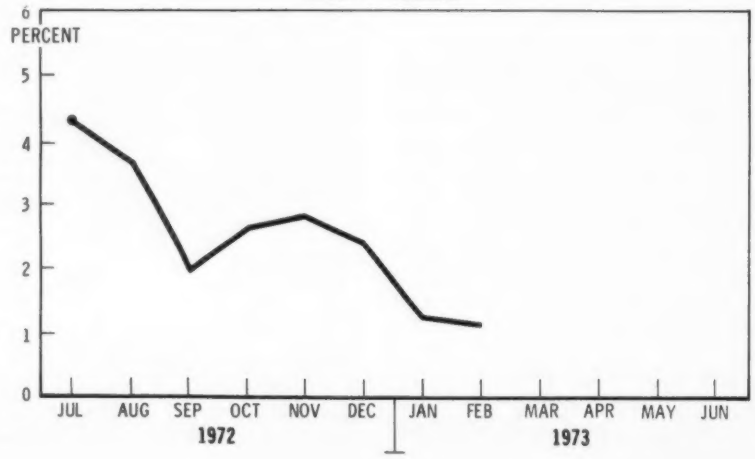
1971	Army	Navy	Marine Corps	Air Force	DoD
JAN - MAR	6,813			155	6,968
APR - JUN	7,511	70		627	8,208
JUL - SEP	8,670	1,390	1,358	882	12,300
OCT - DEC	5,418	2,624	1,695	802	10,539
1972					
JAN - MAR	4,062	2,591	1,094	961	8,708
APR - JUN	4,943	2,262	631	824	8,660
JUL - SEP	2,621	1,789	483	742	5,635
OCT - DEC	1,922	1,392	452	672	4,438
1973					
JAN - MAR	1,918	1,039	481	538	3,976
TOTAL	43,878	13,157	6,194	6,203	69,432

DoD - Vietnam



*Adjusted rate assumes excluded personnel 29 and over are negative.

DoD - Vietnam

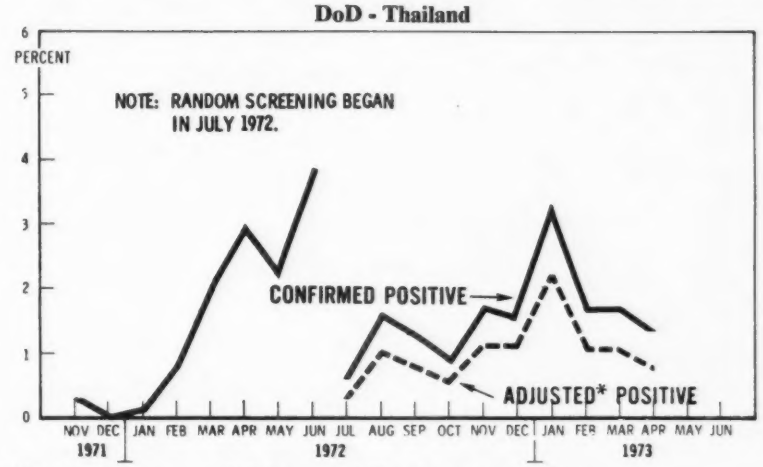


Each Service Conducts Separate Program

The Armed Services were in a most difficult position with regards to rehabilitation and treatment programs two years ago.

Therefore, we commenced an urgent search for methods of treatment that would work, and we determined that we would try any track or modality which offered any promise. We discovered that a Serviceman who was caught up in drug abuse was a very different person from the street addict. In the first place, he was not a highly deviant person whom you would expect to get into trouble. He was instead a young, average American who succumbed to the heavy pressures of family separation and loneliness, ready drug availability, and who was the product of the drug culture which permeates our society. He was living in a highly structured military community, rather than participating in a continual criminal effort on the street to satisfy his habit. He was healthy and showing few, if any, of the physical or mental symptoms of long-term drug abuse.

We began to realize that the highly disciplined but human approach, using many treatment tracks which fitted the best rehabilitation program to each Service member, was very effective and was returning thousands of Servicemen to duty or to normal productive lives outside the Service. We recognized very early from our study of many thousands of drug dependent Servicemen that any form of supportive treatment or maintenance using other addictive drugs, such as methadone, was not necessary and perhaps counterproductive and was not compatible with military duty. We, therefore, elected not to use any form of chemical maintenance and are now convinced that this was the best course.



*Adjusted rate assumes excluded personnel 29 and over are negative.

Different Approaches

Each Service has approached the treatment and rehabilitation problem somewhat differently. The Navy and the Air Force have used a highly centralized program where the drug dependent Service member is placed in one of three large

More than 69,000 Service drug abusers have volunteered for treatment and rehabilitation.

centralized treatment centers. Those not so heavily involved are treated locally in counseling and assistance centers while remaining at their assignment. The Army program, on the other hand, is very decentralized, utilizing many treatment and rehabilitation centers around the world.

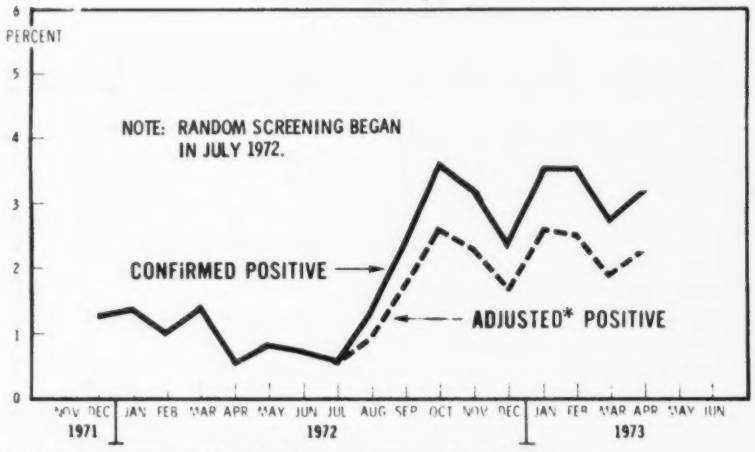
Early in the effort to establish effective treatment programs, the Secretary of Defense determined that the Services should not be involved in long-term rehabilitation and that Service programs should be limited to not more than about 90 days. If longer treatment was necessary, as it was in some cases, personnel should be referred to the Veterans Administration. A Serviceman who desires to continue his course of treatment within the Service, even though his enlistment is expiring, may be retained for as long as appropriate, after which he will be referred to the VA if follow-up treatment is necessary. We now believe that our in-Service and Veterans Administration treatment and rehabilitation programs are succeeding beyond our highest expectations. Who would have believed two years ago that almost all drug abusers and drug dependents could be restored to drug free existence in our society? And as evidenced by the high retention rate of former drug abusers in the Service after rehabilitation, the employment of ex-Servicemen who may have been identified as drug abusers is a good risk.

We know that recovery from heroin dependence is not impossible and that in the case of young, healthy, well disciplined men in the Armed Services, rehabilitation can be successful in a great majority of cases.

Dependents' Care

While our major concern and effort has been concentrated in the provision of adequate treatment capabilities for the Armed Forces, we realized at an early point that a serious drug problem existed among our adolescent dependent youth in certain high risk areas overseas. It was obviously not appropriate to include youthful dependents in the military drug treatment facilities which had been established, although certain of the assets could be used in a dual manner.

DoD - Europe



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After carefully studying the incidence of drug abuse in several American (largely military) communities overseas and surveying the assets which were presently available, we determined to launch pilot programs for the treatment and rehabilitation of youthful drug abusers in certain high risk localities. With the valuable assistance of the Special Action Office for Drug Abuse Prevention (SAODAP), youth treatment centers have been established and are now operating in Bangkok, Thailand, and Frankfurt, Germany.

We are most encouraged by the rapid progress made in the area of adolescent treatment programs overseas. The total community acceptance of these first two treatment centers demonstrates the vital need which they are already fulfilling. We plan to expand this program to meet the needs of each major American military community overseas as rapidly as a need is demonstrated and assistance requested.

DETECTION—The Military Services now use specially trained dogs to sniff-out drugs. The dogs have proven a useful tool in the Services' fight against drugs. (U.S. Navy Photo)

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